KENTUCKIANA
COURT REPORTERS

Case No. 3:20-cv-1123-JDP

Gregory Boyer

V.

Advanced Correctional Healthcare, Inc., et al.

Case No. 3:22-cv-00723-JDP

Gregory Boyer

V.

USA Medical & Psychological Staffing, Inc., et al.

DEPONENT:

KIMBERLY PEARSON

DATE:

February 26, 2025

IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

Gregory Boyer,

Plaintiff,

-VS- Case No. 3:20-cv-1123-JDP

Advanced Correctional Healthcare, Inc., et al.,

Defendants.

Gregory Boyer,

Plaintiff,

-VS- Case No. 3:22-cv-00723-JDP

USA Medical & Psychological Staffing, Inc., et al.,

Defendants.

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VIDEOCONFERENCE DEPOSITION OF KIMBERLY PEARSON

TAKEN ON THE 26TH DAY OF FEBRUARY, 2025

10:02 A.M. CST

REMOTELY VIA ZOOM

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APPEARANCES:

MARIA MAKAR and MADISON IRENE, of the firm of LOEVY & LOEVY, 311 North Aberdeen Street, 3rd Floor, Chicago, Illinois 60607, appeared remotely via Zoom representing the Plaintiff.

DOUGLAS KNOTT and DANIEL KAFKA, of the firm of LEIB KNOTT GAYNOR, 219 North Milwaukee Street, Suite 710, Milwaukee, Wisconsin 53202, appeared remotely via Zoom representing the Defendants Advanced Correctional Healthcare, Inc., Lisa Pisney, and Amber Fennigkoh.

MARK W. HARDY, of the firm of GERAGHTY O'LOUGHLIN & KENNEY, P.A., Wells Fargo Place, 30 East Seventh Street, Suite 2750, St. Paul, Minnesota 55101, appeared remotely via Zoom representing the Defendants USA Medical & Psychological Staffing, Inc., Travis Schamber, and Norman Johnson.

ANDREW A. JONES, of the firm of HANSEN REYNOLDS, LLC, 301 North Broadway, Suite 400, Milwaukee, Wisconsin 53202, appeared remotely via Zoom representing the Defendants Monroe County, Stan

Hendrickson, Danielle Warren, and Shasta Parker.

ALSO PRESENT VIA ZOOM: Alecia Richards
Lauren Hill

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EXHIBITS

(Original exhibits were retained by Attorney Irene)

THE VIDEOGRAPHER: My name is Talia Jackson. I'm the online video technician representing Kentuckiana Court Reporters located at 730 West Main Street, Suite 101, Louisville, Kentucky 40202, and Terri Stacken is the court reporter today.

Today is the 26th day of February, 2025, and the time is 10:02 a.m. Central.

We are convened by videoconference to take the deposition of Kim Pearson in the matter of Gregory Boyer vs. Advanced Correctional Healthcare, Inc., et al., and in Gregory Boyer vs. USA Medical & Psychological Staffing, Inc., et al., pending in the United States District Court for the Western District of Wisconsin. Case No. 3:20-cv-1123-JDP and Case No. 3:22-cv-00723-JDP.

Will everyone but the witness please state your appearance, how you're attending, and the location you're attending from starting with Plaintiff's counsel.

MS. IRENE: Hi. My name is Madison Irene. I am representing Plaintiff Christine Boyer, and I'm appearing virtually over Zoom

from Chicago, Illinois.

MR. KNOTT: Hi. This is Doug Knott. I'm appearing along with my colleagues Lauren Hill, who's a paralegal, Daniel Kafka, who's an associate. We appear for the witness. We appear for Advanced Correctional Healthcare, for Lisa Pisney, and for Amber Fennigkoh.

MR. JONES: I am Andrew Jones. I'm appearing by Zoom from Milwaukee. I represent Monroe County, Stan Hendrickson, Danielle Warren, and Shasta Parker.

MR. HARDY: I am Mark Hardy. I'm appearing on behalf of USA Medical & Psychological Staffing, Norman Johnson, and Travis Schamber, and I'm appearing by Zoom from Minneapolis, Minnesota.

THE VIDEOGRAPHER: All right. And I believe Ms. Richards is joining. I think that's the intern, so I'm just going to let her in before we continue.

Now, Ms. Pearson, can you please state your name for the record.

THE WITNESS: Yes. Kimberly Pearson.

THE VIDEOGRAPHER: Thank you. And, Counsel, once again, off record you indicated

that we would stipulate to the identity of Ms. Pearson.

Is that still true?

MS. IRENE: Yes.

MR. KNOTT: Yes.

THE VIDEOGRAPHER: All right. Then Ms. Pearson, can you please raise your right hand to be sworn in by the court reporter.

KIMBERLY PEARSON,

after having been first duly sworn on oath by Terri Stacken deposes and says as follows:

EXAMINATION

BY MS. IRENE:

Q Okay. Good morning, Ms. Pearson.

A Good morning.

Q I want to begin just by covering a few ground rules. As you're aware, there's a court reporter here and she's going to be taking down everything that we're saying. So we like to try to give loud and verbal answers. Try not to head nod or shake your head. Respond verbally. And try your best not to respond with things like uh-hum because it will just make it easier for the court reporter to understand you.

I will try my best to talk one at a time so

as to not confuse the court reporter as well. If I interrupt you accidentally, please tell me, because I want you to finish all of your answers completely.

Does that make sense?

A Yes.

Q And if you don't understand a question, please say that or ask for further clarification. If you do answer a question, I will assume that you did understand the question.

You may hear counsel objecting throughout this. That's okay. Please still answer the question even if it's been objected to unless counsel otherwise instructs you not to.

Do you have any conditions that affect the truthfulness or accurateness of your memory?

A No.

Q Are you on any medications?

A No.

Q Okay. I'm going to ask you about the opinions listed in your report, and I'm not going to ask you to offer opinions that are not already disclosed in that report.

Does that make sense?

A Yes.

Q Have you been deposed before?
A Yes.
Q About how many times have you been deposed before?
A Somewhere between 30 to 40 times.
Q And have you ever been a main party in a deposition, so a plaintiff or a defendant?
A Yes.
Q When was that?
A It was approximately I would estimate 2016 or '17.
Q And were you the plaintiff or the defendant?
A Defendant.
Q And what was that case regarding? What was it about?
A It was regarding a death in a jail.
Q And what was the outcome of that case?
A I don't recall. I was dismissed.
Q And do you remember the name of that case?
A Not as I sit here today, no.
Q Have you ever been -- so in that case were you being sued?
A I was named in that suit again and then dismissed.
Q And is that the only case in which you've been a

defendant?
A To the best of my recollection, yes.
Q Did you prepare for your deposition today?
A Yes.
Q And how did you prepare for your deposition?
A I reviewed my case file, reviewed the records, reviewed my report.
Q Did you meet with any attorneys?
A Yes, I did.
Q Who did you meet with?
A Mr. Knott.
Q And how many times did you meet with Mr. Knott?
A For deposition preparation, once.
Q Yes. And when was that?
A Yesterday.
Q And for about how long did you meet?
A Couple of hours.
Q And was anyone else present at your meeting with him?
A No.
Q And you said that you reviewed some materials for your deposition.
You said you reviewed your report?
A Yes, among other -- anything in the case file; the records, anything that I had received in

order to write my report.

Q And about how many times did you review these materials?

A I don't understand that question.

How many times?

Q Yes. Did you look over your report once, did you look it over twice, three times in preparation for this deposition?

A I couldn't put an answer to that. I prepared for two and a half hours, so. I would be going back and forth between documents. It's hard to put a number on how many times I read one specific document.

Q Okay. Did you speak with anyone else about your deposition today?

A No.

Q And aside from reviewing the -- those materials that you mentioned and meeting with Mr. Knott did you do anything else to prepare?

A No. I don't believe so.

Q What is your current rate for your services?

A My current rate for review of records, writing reports, is $450 per hour. For deposition it's $500 per hour.

Q And did you sign a retainer agreement with any of

the defendants in this case?
A No, I did not.
Q And when you've worked as an expert in cases in the past how do you typically bill your clients?
A I bill them for work and services provided.
Q And how do you give them -- how do you tell them what work and services you provided?
A I provide a detailed invoice.
Q And as you work on a project how do you keep track of your hours?
A I have a software program that has a timer and I use the timer anytime I'm reviewing anything, and I document exactly what I've reviewed so that I can provide that detail in the invoice.
Q Do you remember the name of the software program that you use?
A I believe it's MyCase.
Q And in a typical case about how often do you issue a bill?
A My main -- my typical practice is to bill monthly.
Q And what's the total amount you've billed in this case to date?
A Well, prior to deposition preparation, over the

course of almost three years, I've billed approximately 45 hours.

Q And do you know what the amount would be?

A I'd need to get my calculator out to do that.

Q That's fine. And so you've already issued bills to Defendants in this case?

A I've submitted bills to Mr. Knott's firm.

Q So when you said that you worked about 45 hours on this case before the deposition today, over what period of time -- you said that period -- sorry. I withdraw that question.

You previously stated you worked about 45 hours of this case, and did you say that that was over a period of three years?

A Not quite three years, but close. It would have been May of '22.

Q And were those 45 hours mostly worked on at one time 40 hours a week or has it been spread out across three years?

A No, it's spread out as documents become available, deadlines, report deadlines.

Q Do you know about how many hours you'll be at including the deposition -- or the deposition preparation?

A Approximately maybe an additional five hours.

Q So do you have an approximate total bill for this case?
A No, because I bill monthly, so I would have to pull all of those and do the math.
Q Did you bring any record of the hours that you've billed in this case today?
A Did I bring it? No. No.
Q And will you bill for every hour that you work on this case?
A Well, honestly, I under bill. I do a lot of thinking that I don't bill for, frankly, so. I will bill for legitimate work hours. I'm very conscientious about being ethical in that arena.
Q What's the reason you feel like you under bill?
A Well, again, I think about things. You know, I may be getting ready for my day this morning and just thinking as I was preparing getting dressed this morning about the case. I'm not billing for that.
Q Are those things that to your knowledge other experts typically bill for?
A I don't ask. I don't -- I don't know. It's just my practice.
Q Are there any other reasons that you feel like

you under bill?

A Well, again, I'm just trying to answer the question as you asked it. You wanted to know if I bill for every single thing that I've done, and I'm just letting you know that I think about these cases and I don't always bill for the time that I may be thinking about something. Again, this morning getting ready I was thinking about the deposition. I'm not billing for that, so.

I bill for time of exactly what's on my fee schedule; records reviewed, development of report, preparation, those types of things.

Q Thank you. Yes, I'm just -- I'm -- I don't bill like that, so I'm just trying to get a better understanding of your -- of your billing practices and what you do and don't bill for.

Okay. I'm now going to briefly -- I'm going to take myself off and pause for a moment to share my screen.

Can you see my screen clearly?

A Yes, ma'am.

Q I'm marking this as Plaintiff Exhibit 1.

Do you know what this is?

A That's the first page of my CV.

Q And is this your most current and up-to-date

CV?

A Can you -- can you stop?

Q Yes, I'll go slower. Sorry.

A I just need to see the date on the second page. 1-1-25. Yes, it is.

Q And is everything on it true and accurate?

A Yes. To the best of my knowledge, yes.

Q What degrees do you have?

A As on page 2, a master in business administration, a master of science in healthcare administration, a Bachelor of Science in health, and a diploma in nursing.

Q Were you ever put on academic probation at any time?

A No.

Q Can you talk to me a bit more about the first job that you had.

What were your responsibilities there?

A Which one are you referring to?

Q Well, I guess I'll ask you. Is this El Camino Hospital-Mountain View, the psychiatric unit, assistant nurse manager, was that your first job?

A No. I've worked since I was in high school. These are relevant nursing positions.

Q So was that your first job that you worked after you got your diploma in nursing?
A I -- I may have worked for a nursing home for a few months while I was in transition moving to California. But essentially, yes, this was my first nursing job.
Q Why did you leave the nursing home position?
A Well, again, I was moving from Illinois to California, so it was -- I just was paying my bills and getting ready to move and moved and then took this position in California.
Q So this position at the El Camino Hospital was your second job after receiving your diploma in nursing?
A Perhaps.
Q Is there some reason that you believe you would have worked other jobs in between that?
A No.
Q And what were your responsibilities there?
A Well, I worked, as is noted there, on the medical unit, the nephrology unit, the psychiatric unit, and then was an assistant nurse manager for a time.
Q And why did you leave that position?
A I relocated to Illinois.

Q And when you relocated to Illinois was your first job there at this Proctor Hospital as a nurse manager?

A Yes.

Q And what were your responsibilities as a nurse manager?

A I was the nurse manager of the medical respiratory unit. I was responsible for all of the patient care in that unit, for nurse hiring, nurse training, budget, all of the things that a nurse manager is responsible for.

Q Okay, yes. Thank you. Sorry, I'm asking these questions because I don't know all the things that nurse managers are responsible for, so it's helpful to clarify.

And why did you leave that position?

A I had an opportunity at OSF Saint Francis that I wanted to take.

Q And what made that opportunity more attractive to you?

A It's where I went to school and it's where I wanted to ultimately work. It's a trauma center. It gave me extensive clinical experience, much more well-rounded.

Q And after that you have listed OSF Saint Francis

Medical Center, so the same place, but emergency medical services systems manager.

A Yeah.

Q Was that change in job a promotion or was it just a change to a different department, different responsibilities?

A I guess I would say it's a change in responsibilities, different department.

Q And what were your responsibilities in emergency medical services?

A I was responsible for the largest EMS system in the State of Illinois in terms of EMS provision to the communities. I believe I had 2100 paramedics and EMTs in my system. I was responsible to ensure their training and licensure was adequate. We provided training.

I also headed up -- it was shortly after 9-11. Homeland Security dollars were flowing for systems to create disaster response teams, so I put together disaster response teams to provide services to the outlying communities in the region.

Q And why did you leave that position?

A I relocated to New Mexico.

Q And in New Mexico it says you worked at Gallup

Med Flight.

Can you talk -- what is Gallup Med Flight?

A Gallup Med Flight's a medical flight program. It was critical care flight transport out of Gallup to larger facilities.

Q And why did you leave that position?

A That position was 24/7 and -- literally. I was a flight nurse. And it just was -- it became somewhat exhausting, honestly, all the hours, so I made a move to something a little more family friendly.

Q And you were in New Mexico until 2009; is that right?

A Yes.

Q And then you went to the Orange County Health Care Agency in Santa Ana, California; is that right?

A Yes.

Q And what made you make that move?

A Moved to California.

Q And why did you want to work for Orange County Health Care Agency in Correctional Health Services?

A I had an interest in serving that population.

Q Can you describe your current role at KP

Consulting.

A So I provide correctional health care consulting services to jails and prisons across the country. I look at -- I do a lot of things in my consulting program.

I have worked on behalf of the Board of Registered Nursing in cases, reviewing cases in correctional settings. I've worked with private healthcare companies. I've worked with counties developing their contracts, doing their RFP development, worked with the National Commission on Correctional Health Care doing technical assistance inspections for different counties.

It's very varied the projects, but it's all correctional health related.

Q Just to clarify, everything that KP Consulting does is correctional health related or everything that you do at KP Consulting is correctional health care related?

A Both. It's my company.

Q And how many other people are employed at your company?

A None.

Q And is my understanding correct that you serve both as program consulting regarding

administrative and clinical operations and as expert -- an expert witness for correctional health care cases?

A Yes.

Q And can you estimate about what percentage of your work is working as a program consultant.

A Well, I'm going to answer that in this way. I have decided to retire, and so I stopped taking new cases last year. I also stopped taking consulting projects. I just recently in the last four weeks turned two down.

And so at this point I am just trying to finish up depositions and trials that are left on my calendar.

Q Well, congratulations on retiring. But so I guess before, from 2014 to I guess 2024, can you estimate about what percentage of your work was working as a program consultant.

A Oh, that's a little complicated too. It's not a simple answer, because from 2014 until 2018 I was working at Orange County Health Care Agency, so I was doing some expert work very, very part-time during 2014 to '18.

Then I retired from Orange County in 2018, and that's when I started doing both. I was

doing consulting at that point.

Typically, I would -- how it unfolded was I think the most that I would bill is about 40 hours. I worked full-time, so 40 hours in any given month on expert case review and otherwise it was in various consulting projects. So maybe a fourth of my time.

Q Looking at -- or thinking about all the jobs that you've ever worked at, have you ever received any disciplinary action in any of your jobs?

A Absolutely not.

Q And were you ever fired from any of your jobs?

A No.

Q I'm marking this as Plaintiff's Exhibit 2.

Do you recognize this?

A Yes.

Q And what is this?

A A case testimony list that's required by Rule 26.

Q So as of now how many cases are you currently handling?

A As of right now?

Q Yes.

A I would estimate 17 are open. However, I only believe that there are about nine with

depositions or trials on the calendar.

Q And before you retired did you have -- can you estimate the amount of cases you handled in your capacity as an expert witness.

A Well, due to the nature, I mean, I have cases that date back to 2015, honestly. So some of these cases go on, unfortunately, for nine, 10 years. So, you know, some of those cases I hadn't even looked at in multiple years.

But I would say before I decided to retire I probably had about 45 total caseload that was open. Again, many just sit there and there is no action. And every year I have a practice in January of contacting all of my open case attorneys to see what's going on with the cases because very, very frequently experts are not informed when cases have settled or, and so I typically every January close out multiple.

Q This case testimony list, this is every case that you've ever testified in trial for --

A No.

Q -- for the last four -- sorry, I apologize. For the last four years; right?

A For the last four years, yes.

Q So before these last four years do you know about

how many cases you testified as an expert in trial for?

A No. I don't recall off the top of my head.

Q Do you know if it was dozens?

A No. No.

Q In any of these cases were you testifying on behalf of the plaintiff? I apologize. I'll withdraw that question.

Looking at this, at your case testimony, in any of these cases listed on this document were you testifying on behalf of a plaintiff?

A On the entire document?

Q Yes. And if you need a minute to look it over, that's more than fine too.

A Right. Right. Again, this is a four-year snapshot, so I have certainly testified on behalf of plaintiffs before. But this four-year snapshot, you know, there is -- there is -- there is a plaintiff case in here definitely.

Q Which case is that?

A Pendermon vs. Hounshell.

Q And is that the only case on this list in which you testified on behalf of a plaintiff?

A Yes. Again, on this particular four-year list. I have testified on behalf of plaintiffs in other

matters.

Q About how many times have you testified on behalf of a plaintiff?

A I can't provide you an answer to that without going through my entire case file.

Q Are you able to estimate the proportion of cases that you worked on where you were retained by a plaintiff?

A Yes. Yes, I can estimate. 25 percent.

Q And looking again at your case testimony sheet, have you -- I apologize about that -- have you -- do any of these cases involve claims of injury from a significant delay of medical care?

A I'd have to go through. I don't recall all the specifics of these cases. I apologize. I don't recall.

Q Okay. How do you go about getting your work?

A I'm sorry, what?

Q How do you go about getting your work? How do you go about -- how -- how do you go about getting these expert witness positions in these cases?

A I'm contacted by an attorney, and then we have a discussion about their needs and my availability and if I can help them, if I have a conflict,

whatever it may be, and then I either accept the review or not.

Q And do you advertise?

A No.

Q Have you ever been excluded as an expert witness in a case before?

A No, I have not been excluded.

Q In what subject areas do you consider yourself to be an expert in?

A Well, my focus is solely correctional health. So correctional health administration, operations, nursing. I think that covers all of it. Administration, operations, and nursing.

Q Okay. Sorry. And are there any subject areas that you do not consider yourself to be an expert in?

A I'm not even sure how to answer that question. Could you ask it in a different way?

MR. KNOTT: Objection. Overly broad.

Q (By Ms. Irene, continuing) Is there anything to do with, for example, any of the -- sorry, I'll withdraw that.

When it comes to correctional health care administration, is there any subject or part of that in which you, for example, would say I

really know this stuff, but I don't know this. This is a part of correctional health care that may come up regularly but I've never worked in that, I'm not an expert in it?

MR. KNOTT: Object to the form of the question. But you may answer.

A Well, it depends. I really -- I don't know how to answer that question. I mean, it would depend on the circumstances that were presented. I would just need to review the facts. And if it's something that I did not feel I had experience in, then I would certainly relay that information to the attorney.

Q (By Ms. Irene, continuing) Okay. I'm going to show you Plaintiff's Exhibit 1 again. This is your CV.

Looking at your Professional Affiliations, can you tell me what Jail Accreditation Surveyor is.

A Yes. So the National Commission on Correctional Health Care provides accreditation to facilities who choose to pursue accreditation. Similar to if you do medical cases similar to the Joint Commission provides accreditation for hospitals, National Commission provides accreditation for

jails.

When a jail or a prison wants to pursue accreditation, then an accreditation team of surveyors comes into the facility for several days, does a lot of work in advance as well reviewing policies and procedures, and then looks at all their clinical operations, administrative operations in light of and in comparison to the standards to determine whether they meet accreditation standards.

Q Okay. And can you tell me more about your association with the American Correctional Health Services Association.

A American Correctional Association?

Q Yes.

A Is that what you said?

Q Yes. American Correctional Health Services Association.

A Oh, okay. Yes. So I was a previous chapter board member for that association for several years. And the primary goal of that association at the time was to provide educational content for correctional health professionals in California and Nevada and Oregon and Washington, I believe.

Q Okay. And looking at your Professional Certifications, can you talk to me more about what your CCHP certification is?

A Yes. So the National Commission on Correctional Health Care offers individuals the opportunity or option to be a Certified Correctional Healthcare Professional.

And so that requires working in the field as well as sitting for an exam, successfully passing that proctored exam, and then maintaining and submitting annual continuing education hours to support recertification, and with the vast majority of those being in correctional health-specific issues.

Q And what's your Six Sigma Green Belt certification?

A So Six Sigma is a process-driven methodology that -- it's well-known in manufacturing specifically, but it's really about process evaluation. And so when I was at Saint Francis Medical Center in Illinois they developed a Six Sigma team to look at processes.

And so the thought is that rather than a nurse manager who's doing a hundred different things over the course of the day and is putting

out fires rather than proactively trying to identify and manage and mitigate problems, the Six Sigma team comes in and they are just dedicated to that -- dedicated to that project and problem.

So, for instance, if -- one of the projects we worked on was we were seeing an increase in pneumonia in our ICU patients on ventilators. So this team went in and started going through all of the documents, it's extensive review, analysis, problem-solving, that kind of methodology. So it's really research and methodology and process management.

Q Okay. Looking at your Consulting Contracts, the first one that says expert witness and correctional health care consultant, is -- what is that contract?

A Well, it's not a contract. That's just a -- it's just providing information about one of the things that I do. Some of them have a written contract. Some of the projects do not.

Q Okay. So looking at, for example, Medical Horizons Consulting, what -- why do you have that listed as a consulting contract? Can you explain to me more about what that is?

A Sure. This is just a chronology just showing my -- the history of my clinical experience.

And so again, after being in the EMS venue and being a disaster response leader for the State of Illinois, I was hired -- a consulting contract with Medical Horizons back in it says 2009-2010, public health and disaster preparedness. And so I was assisting them with various projects based on my clinical expertise at the time.

Q Okay. So you've done consulting work also on oncology administration?

A Yes.

Q And on medical malpractice?

A Yes.

Q And have you ever served as an expert witness for any of these other things that you did consulting work for aside from correctional health?

A Could you repeat the question, please?

Q Have you ever served as an expert witness on any of these other things that you did consulting work for aside from correctional health?

So, for example, have you ever served as an expert witness on disaster preparedness?

A Understood. No, I have not.

Q Okay. And looking at your -- the list of Publication Review, Presentations, and Teachings, did you do a manuscript review for The Nurse Practitioner, "The Implications of eDiscovery for the Nurse Practitioner".

A Yes.

Q And what was that about?

A That was --

MR. KNOTT: I'm sorry, could you -- could you -- you're on page 4, and could you take me to that? Tell me approximately where that is.

MS. IRENE: Yes. At the top of page 4 of Plaintiff's Exhibit 1, actually.

MR. KNOTT: Okay. Thank you.

Q (By Ms. Irene, continuing) You can answer, please.

A So that was from 2019, so I honestly don't recall all of the content in that particular article.

However, I will say that because of my extensive work in electronic healthcare records, it was really not so much about a nurse practitioner. It was more focused on the eDiscovery, electronic record, that type of thing.

So I just reviewed it from a content standpoint and then provided my input as to -- well, you provide a lot of different input on manuscript review in terms of the resources they used and the content.

Q And in 2018, in the fall of 2018, were you interviewed for a journal publication called "Tales from the Court: Experienced LNCs at Trial and Deposition" by the American Association of Legal Nurse Consultants.

A Yes.

Q And what was that interview about?

A I honestly do not recall.

Q And in September of 2017, I'm looking still at page 4 of Plaintiff's Exhibit 1 towards the lower half, were you a speaker at the California-Nevada Chapter Conference for the American Health Services Association at an event called "Clinical Management for High-Risk Patients in this Litigious Environment."

A No, not as you stated it. It was for the American Correctional Health Services Association, and it was not -- the event was not called "Clinical Management for High-Risk Patients in this Litigious Environment". That

was the name of a presentation.
Q And you were a speaker at that presentation?
A Yes.
Q And do you remember what you spoke about?
A High-risk patients in jail and prison settings.
Q And do you remember anything more specific you were speaking on that subject about?
A Not specifically, no.
Q And looking at the top of page 5, were you a speaker for the California State Association of Counties at their annual conference in Palm Springs, California, December 2016, at a talk that was titled "Responding to Inmate Advocacy Groups and Preventing Jail Lawsuits".
A Yes.
Q And do you remember what you spoke about?
A No, I do not. It was a panel discussion, so it would have consisted of a lot of questions and answers.
Q Okay. Sorry. Just give me one moment. And in December of 2016, I'm still looking on page 5, did you do a manuscript review of a work that was titled "Being a Culturally Competent Nurse: A Nursing Student, Why and How".
A Yes.

Q And it says Nursing 2016. Is that a journal? A magazine? What is that?

A Yes. It's a journal slash magazine. It's Nursing, and every year the title changes to the current year. So this year it's Nursing 2025. That year it was Nursing 2016.

Q Okay. And sorry, I only have a few more of these for you. In -- looking at page 6 now of Plaintiff's Exhibit 1, in April of 2013 did you do a manuscript review for that same Nursing 2013 titled "When Patients Are Also Inmates: Providing Nursing at a Correctional Facility".

A Yes.

Q Okay. And then in July of 2007, looking at the top of page 7, did you do a manuscript review for Nursing 2007 on an article titled "Code STEMI: -- S-T-E-M-I -- Better Care for Cardiac Patients".

A Yes.

Q And what is Code STEMI?

A I don't recall anything about this article, frankly, from 2007.

Q Okay. Thank you. One moment. I'm going to stop sharing my screen.

Okay. Ms. Pearson, in your review of materials for this case, were there any materials

that you asked for but were not provided?

A No.

Q And is it fair to say that attorneys selected the documents that you reviewed?

A Yes, I suppose I would say that's fair. They sent me the records they wanted me to review.

Q Is there any reason that you feel like that's not an accurate statement?

A How this process works for me is I'm sent materials by the retaining attorney. And if there's something that is referenced that I don't have or that I think I need I ask for that, and they may or may not have it, and that's just how the process works.

So I don't know how they determine -- well, let me say this. There are certainly things if I've been asked to opine on one thing, I may not need 10 things that aren't related to that, and that's their decision. Again, I accept and review what they send. And if I need something different, I believe I need something different, I ask.

Q Okay. And in this case you did not ask for anything additional?

A I don't believe so.

Q Is there any reason why you didn't ask to see anything other than the materials that you were given?

MR. KNOTT: Form.

A Did someone say something?

MR. KNOTT: I objected to the form. I'm sorry. I maybe need to speak a little bit to catch my microphone.

A So I received documents that I felt were appropriate for me to formulate my opinion.

Q (By Ms. Irene, continuing) Okay. I'm going to share my screen again. Is this -- can you all see this as well? Is this screen sharing in the way on the top of this document? I'll just try to move it. I don't know if you can see it or not.

Ms. Pearson, do you recognize this?

A Yes.

Q And what is this?

A That is the report that I authored related to this case and submitted.

Q And is everything in your report true and accurate?

A To the best of my knowledge, yes.

Q Okay. In general, as serving as an expert

witness on correctional health cases, what methodologies do you use to review materials?

A So I review the materials that are provided to me. And then based on my training, my education, my licensure and scope of practice and my experience, 40 years in nursing, and in correctional health since 2010, then I formulate my opinion based on all of those things combined.

Q And what methodologies did you use in your analysis of this case?

A Same.

Q What does the term "standard of care" mean?

MR. KNOTT: Object to the form of the question. To the extent it calls for a legal conclusion, but -- or a legal definition.

But you can go ahead and answer.

A My -- how I would describe standard of care based on my understanding is what a same or similar individual would do in the same or similar circumstances.

Q (By Ms. Irene, continuing) And what is a differential diagnosis?

A Well, I have an understanding of that based on my nursing education. I do not provide differential

diagnosis. That's outside of my scope.

So I can provide you with my understanding of the definition of differential diagnosis based on my years in nursing if you would like me to provide that, but it's outside of my scope.

Q Okay. Yes. Could you provide me with your understanding of what a differential diagnosis is from your experience as a nurse.

A So a differential diagnosis is the various conditions that a physician, nurse practitioner, physician assistant, may be considering in terms of diagnosing a patient. There may be -- they may have symptoms that are reflective of numerous conditions.

And so they, more often than not, they'll list all of those things in their differential diagnosis saying we're going to try to rule this out, rule that out, rule this out until we get to a final diagnosis.

Q And what is your understanding of why differential -- or I'm sorry, are differential diagnoses important?

A This is outside my scope at this point.

Q Okay. So you're saying that you don't have an understanding of why differential diagnoses are

important?

MR. KNOTT: I think she explained the scope of her nursing practice. It's outside the scope of her opinions in the case. And it's also an incomplete hypothetical so that someone trained in differential diagnosis would have a hard time answering. But I guess --

A Yes, I'm not -- I'm not trained in -- in providing differential diagnosis. I, of course, as a nurse will read that in hospital records or emergency department records.

And I understand that the provider -- and when I say "provider" going here forward, I'm talking about a physician, a nurse practitioner, or a physician assistant, people who diagnose and prescribe -- that they utilize differential diagnosis, I read that and know that they're looking at these various things trying to get to their final conclusion.

That's the extent of my -- I don't have any training in providing differential diagnoses.

Q (By Ms. Irene, continuing) Okay. Thank you for that, Ms. Pearson.

MS. IRENE: And, Mr. Knott, I'd just

ask, I'd appreciate no speaking objections in the future.

Q (By Ms. Irene, continuing) Ms. Pearson, are you aware of, do you know what an "anchoring bias" is?

A I cannot provide you with a definition of that as I sit here right now, no. I may have read about that in the past, but it's not anything I can come up with a definition for right now.

Q And are you aware of or do you know what "premature closure" is?

A I don't even know what that's --

MR. KNOTT: Objection. Vague.

A I don't know what that's in reference to.

Q (By Ms. Irene, continuing) Do you know the difference between a nurse and a nurse practitioner?

A Yes.

Q What is the difference between a nurse and a nurse practitioner?

MR. KNOTT: Object to the form of the question. It's vague. But go ahead.

A Well, at a very basic level, a nurse practitioner has additional education beyond that of a registered nurse and is by education, training,

and licensure able to diagnose and prescribe medication, whereas a registered nurse cannot.

Q (By Ms. Irene, continuing) Would you agree with me that a nurse serves as the eyes and ears of a medical team?

MR. KNOTT: Object to the form of the question. It's vague.

A No, I wouldn't word it that way. I -- a registered nurse gathers information and provides information as clinically necessary to higher-level providers when clinically necessary.

Q (By Ms. Irene, continuing) Have you ever heard the phrase that "nurses are the vanguard", the vanguard for observing changes in a patient's system -- or symptoms?

A No, I've never heard that phrase.

Q And would you agree that nurses act as a sort of hub of communication between physicians or practitioners and patients and their families?

MR. KNOTT: Object to the form of the question.

A No, I wouldn't agree. It depends on the setting. It depends -- it depends on the circumstances.

Q (By Ms. Irene, continuing) So can you say more

why don't you agree with that?

A Well, just one of many issues. One example would be, as you worded it, nurses in jail settings aren't routinely calling families, whereas that may be more common in another setting. So I just -- I can't agree with how you worded it.

Q Okay. Sure. So I guess I'll take out the families.

Would you agree that nurses act as a sort of hub of communication between physicians and patients?

MR. KNOTT: Object to the form of the question. Vague. And vague as to circumstance.

A No, I wouldn't agree. I wouldn't call them a hub. I would say exactly what I said I think the previous couple of answers ago, that nurses do provide information -- clinically relevant information to a higher-level provider when it's clinically necessary and justified. So there is that communication that does occur.

Q (By Ms. Irene, continuing) Are nurses a main source of information for physicians about getting information for patients?

A It depends on the setting.

MR. KNOTT: Objection.

Q (By Ms. Irene, continuing) Would you agree that effective communication in nursing is important for providing the best and safest possible care?

MR. KNOTT: Object to the form of the question.

A Could you repeat, please.

Q (By Ms. Irene, continuing) Would you agree that effective communication in nursing is important for providing the best and safest patient care possible?

A I think communication is important when it's clinically necessary.

Q And would you agree that clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing?

MR. KNOTT: Object to the form of the question. It's vague and overly broad.

A I -- yes. No, I wouldn't agree to how that was phrased at all. No.

Q (By Ms. Irene, continuing) Okay. Why don't you agree?

A Could you repeat all of your qualifiers, please.

Q Yeah. Would you agree that clear, accurate, and accessible documentation is an essential element

of safe, quality, evidence-based nursing?

MR. KNOTT: Object to the form of the question. It's vague. Overly broad.

A Yeah, again, it depends on -- it depends on the situation.

Q (By Ms. Irene, continuing) When would you not want documentation to be clear, accurate, and accessible?

MR. KNOTT: Object to the form of the question. It's vague and overly broad.

A Well, it's not that I don't want that. It's just, again, it depends on the situation.

For instance, I have certainly been a part of a telehealth encounter where there's a physician on the other side of the screen and I am the nurse and with the patient. The physician doesn't have my documentation in front of him.

So that's just one of many points that -- that's not accessible at that point, but it doesn't mean that that interaction is not appropriate. It certainly is.

Q (By Ms. Irene, continuing) Yes, I guess I am asking when there -- when there is documentation, do you agree that's important that that documentation be clear, accurate, and made

accessible?

MR. KNOTT: Object to the form of the question. It's vague and overly broad.

A I believe that documentation should be accurate and I believe it should be maintained.

However, the system in question, and systems do it differently, however they maintain their patient records.

Q (By Ms. Irene, continuing) Would you agree that nurses are one of the primary people who are able to observe a patient's signs and symptoms?

A Well, that --

MR. KNOTT: Object to the form of the question. It's vague and overly broad.

A That completely depends on the circumstances and the venue.

Q (By Ms. Irene, continuing) As a nurse are you trained to catch changes in a patient's condition?

A Nurses are trained to observe.

Q And what are nurses trained to observe?

A Nurses are trained to consider the subjective information they receive from a patient and then make their observations to determine whether the subjective and the objective information seems

accurate. So it depends on the situation, what they're observing.

If someone comes into the emergency department and they think they have a broken finger, we're observing their finger, not necessarily looking at their feet.

Q And are nurses trained to observe changes in symptoms of patients?

A Well, that -- that's a generality. Again, of course, it depends on the situation.

Q What are some of the situations where nurses would be told to not observe changes of symptoms in patients?

MR. KNOTT: Object to the form of the question. It's a vague and overly broad hypothetical.

A Right. I would not characterize it as nurses being told not to observe.

But as you've asked it, for instance, if I walk by a patient that I've never seen before I don't have any prior baseline, so I don't know if there's been a change in that patient or not.

So again, it depends on the situation. You know, are you a nurse that you have eight hours assigned to one patient in a hospital. I'm

assuming when you're dedicating eight hours to that one patient you might observe -- you would likely observe changes.

But in a jail, as I'm walking by someone that I've never seen before, I can't tell you if they've had a change. I don't know anything about them prior to my walking by. So it depends --

Q (By Ms. Irene, continuing) Sure.

A -- on the situation.

Q Sure. So to clarify, are nurses trained to observe symptom changes in patients that they are -- have already had previous interactions with or that they are assigned to?

MR. KNOTT: It's vague and overly broad, but go ahead.

A Well, nurses are definitely trained to observe. And if they notice clinically relevant changes, then yes, they would report clinically relevant changes.

Q (By Ms. Irene, continuing) In general, and I understand that this may not be in every single case, but in general do nurses see patients more than physicians?

A Well, that completely depends on the venue.

Q Okay. In your experience, do nurses see patients more than physicians?

A In 40 years, as we went through my CV, I've been in so many venues, they're all completely different. So again, it depends on the venue.

Q Okay. In correctional health care facilities, in your experience, do nurses typically see patients more than physicians?

A So that depends on the size of the facility and how that's staffed.

Q Have you worked at facilities where physicians see patients more than nurses?

A I don't know how to answer that question. I can tell you that there are often more nurses on staff than physicians in terms of that ratio.

Q Were you unaware at your previous correctional health facility how often nurses as opposed to physicians saw patients? Are you saying you don't know?

A Am I unaware of what? Could you reask?

Q Of how often physicians and nurses saw patients?

A I'm aware of how often nurses and physicians saw patients, but I had 10 buildings and 7,000 people and so I don't tally that. Again, there are more

nurses than there are physicians in my system. Again, it depends on the particular facility and how they've staffed it.

Q Sure. But if you're aware of how often nurses saw patients and how often physicians saw patients, all I'm asking is if you're aware of if nurses saw patients more than physicians?

MR. KNOTT: Object to the form of the question. It's vague, and it's asked and answered.

A So I want to answer your question, I just don't -- it's difficult as you have asked it in that my physicians were seeing patients all day long. Whereas my nurses, even though there were more of them, may not have been seeing patients all day long. Or they may have been grouped in one area seeing all the intakes that were coming in and not in the other nine housing units -- or nine buildings. So it's hard for me to answer as you've asked it.

Again, there are more nurses on staff in a larger system than there are physicians, but it still depends on the size of the facility and how they've chosen to staff it.

Q (By Ms. Irene, continuing) Okay. So as I've

asked it, it's your -- you're unaware of in the correctional facilities that you oversaw who saw patients more, nurses or physicians?

A No, I'm not unaware.

MR. KNOTT: Object to the form of the question. It's argumentative. Asked and answered.

Go ahead.

A I'm not unaware. I'll repeat it. There are more nurses, there were more nurses in my system than physicians. But you're asking me numbers, and my physicians were seeing patients all day long. And there were times when nurses were not, but I had more nurses. So --

Q (By Ms. Irene, continuing) Yes, I understand that there were more nurses. And you're right, I'm not asking about if there were more nurses.

I'm asking if you know who had more frequent contact with patients, nurses or physicians, or do you not know?

A It completely depended upon the patient. There were some patients that saw physicians more frequently than nursing staff, and some who saw nursing staff more frequently than physicians, and some who didn't see anybody because they had

no medical needs.

Q Okay. So there was no trend?

A Trend, no. Again, there are more nurses than there are physicians.

Q Is it part of making sure a patient is safe and receiving adequate care that nurses be good listeners?

A Could you repeat the question, please.

Q Is it part of making sure a patient is safe and receiving adequate care that nurses are good listeners?

A Nurses are trained in the provision of care to be a good listener.

Q And why are they trained to do that?

A Well, back to the subjective and objective information, that's what nurses are trained to do is to gather subjective, which means listening to what the patient says. And then also observing other information about the patient.

Q And would you agree that it's important for nurses to be good listeners?

A It's important for nurses to gather subjective information. So to hear what the patient's saying, I guess you could say they need to listen.

Q And would you agree that this is important because if nurses are not listening closely to gather that subjective information, there could be dangerous or harmful consequences?

MR. KNOTT: I'll object. It's vague and overbroad.

A No. I'm sorry. Go ahead.

MR. KNOTT: I was objecting that it's vague and overly broad. Sorry to interrupt.

A No. Nurses are obtaining subjective information, and only the subjective information provided to them, so you can't tie the two together. And a patient may not be forthcoming and may not tell the nurse everything.

That's certainly not -- that doesn't go down a trail of the nurse didn't do his or her job or didn't do it well. They're only able to take in the subjective information the patient offers.

Q (By Ms. Irene, continuing) So to be clear, Ms. Pearson, I'm asking about the subjective information that the patient offers.

Would you agree that if a nurse does not do a good job taking down that subjective information that the patient offers, that it can lead to harmful or dangerous consequences?

A Well, it depends on the situation. It depends on the situation.

Q One -- one moment.

MR. KNOTT: Madison, if we get to a breaking point, we've been going at it about an hour and 15 minutes.

MS. IRENE: Yes, I only have a few more questions sort of left in this section, so I think we should be coming up on one soon.

Q (By Ms. Irene, continuing) But, Ms. Pearson, I just want to follow up.

So in what situation would a nurse not accurately taking down the information that's being told to them not potentially lead to harmful or dangerous consequences?

MR. KNOTT: Object. It's vague and overly broad.

A So let me give you an example. If a patient said I'm diabetic and I need insulin, and the nurse said yeah, yeah, yeah, and turned around and walked away, that would be a serious consequence.

On the other hand, if a nurse -- or a patient said I need 10 Band-Aids for my foot, I keep these Band-Aids on my foot, and the nurse didn't necessarily write that entire conversation

in their note and it really had -- it wasn't a clinical medical issue, it was just something the patient for whatever reason wanted to do, that would not necessarily lead to a serious problem.

Again, it completely depends on the scenario.

Q (By Ms. Irene, continuing) Okay. But, Ms. Pearson, that's not what I'm asking. I'm not asking if in every single situation that a nurse doesn't write down the subjective information that they're being told that it will lead to harmful consequences.

What I'm asking is if a nurse does not accurately write down the subjective information they're being told to them, could it lead to harmful or dangerous consequences for the patient?

MR. KNOTT: I'm objecting to the form of the question. You're getting argumentative.

You asked her to list circumstances in which it would not be harmful, so you were asking her to explain every circumstance.

But I object to the form of the question. It's vague, overly broad, and

asked and answered.

A So taking down subjective data consists of, in a medical record, for the purposes of continuity, is to record the clinically relevant information.

So when a patient comes in and says -- or you say hi, how are you, and they say fine, we're not writing that in the chart.

So again, it's clinically relevant data, as in my example, if a patient provided information about something and the nurse said oh, yeah, whatever, and walked out of the room, that would be a problem.

But nurses are trained to write down the clinically relevant subjective information provided by the patient.

Q (By Ms. Irene, continuing) And if a nurse incorrectly writes down or omits parts of the clinically relevant subjective information, could that lead to harmful and dangerous consequences for the patient?

MR. KNOTT: Object. It's vague.

Overly broad.

A If you'd like to use the example I gave you, that potentially could be a harmful situation if a nurse walked away and didn't write anything down.

Q (By Ms. Irene, continuing) But to be clear, even if a nurse writes some things down but does not write down all of the clinically relevant subjective information that a patient provides, it could lead to dangerous or harmful consequences for the patient?

MR. KNOTT: Object to the form of the question. Asked and answered. Vague and overly broad.

A It depends. No, I would say that's not a -- that's just not a 100 percent statement at all.

Again, you have to understand that the nursing process includes subjective and objective, so it's a combination of the two.

Q (By Ms. Irene, continuing) Okay. Yes, I've been saying subjective because that's what you've been using. But to be clear, I'm asking about subjective and objective information.

If a nurse fails to write down some of the clinically relevant subjective and objective information, could you --

A You've only been asking subjective. But --

Q Okay. So why is that difference important to you? Why -- what is -- why is that difference important to you?

A Well, it's very important. It's very important.

For example, again, the patient is going to tell you what the patient chooses to tell you. And they may be fully forthcoming and they may not and they may be confused. I mean, there's any number of scenarios.

And then the nurse uses objective evaluation. We'll use this case. Ms. Boyer told Nurse Fennigkoh that she -- I'm using her words -- she was peeing as she was standing there. That's her subjective.

The objective information that Nurse Fennigkoh documented was that she was standing in front of her, she had on, I don't know if it was tight pants, yoga pants, some sort of formfitting pants, and there was no urine noted. That's the objective. So you have to consider both.

Q Okay. So in the future, if I'm asking you a question that you feel like you can't answer or I'm missing something important like that, I would just ask that you let me know how the question can be changed so that you can better answer it. So I will ask you --

MR. KNOTT: That's an improper instruction. You can't put that burden on

her. You have to ask the question and she'll answer it.

Q (By Ms. Irene, continuing) Okay. So I'll ask you now about objective information.

If a nurse omits clinically relevant objective information, could that lead to -- could that lead to danger or harm for the patient?

MR. KNOTT: Object to the form of the question. It's vague and overly broad.

A Again, always depends on the situation and the circumstances.

But yes, if the patient is unconscious on the floor and the nurse walks away and does not document that or take action, that would be potentially harmful.

Q (By Ms. Irene, continuing) Okay. But what I'm asking is not just in the situation where a patient is passed out on the floor and a nurse walks away.

I'm asking if in general, if a nurse omits clinically relevant information, could that lead to potential harm or danger for the patient?

MR. KNOTT: I need to object to the form of the question. It's vague as to

circumstance. It's overly broad.
A Okay. As I understand you asked it, if the nurse omits clinically relevant information, could that be harmful?
Q (By Ms. Irene, continuing) In short, yes.
A Again, it depends, because there may be clinically relevant information that the patient has not provided. Therefore, a nurse cannot document something that a nurse is unaware of.
Q Okay. And if a nurse omits clinically relevant information that a patient has provided, could that lead to potential harm or danger for the patient?
MR. KNOTT: Object to the form of the question. Vague and overly broad.
A Again, it depends on the situation. Potentially it could be, but not in every case.
Q (By Ms. Irene, continuing) Okay. And one of the ways that nurses give information is through documentation in medical records; is that right?
A Yes. Nurses document their patient care.
Q And is one of the reasons why they do this in order to make sure that a physician is aware of all the information that they have received?

MR. KNOTT: Object to the form.

A I would not describe it in that way. Nurses document in the record because they have been trained to do so for purposes of tracking what has occurred with the patient clinically, and any number of individuals may look at that record. It's not specifically for a physician per se. It's medical team.

Q (By Ms. Irene, continuing) Okay. And do nurses rely on physicians reading the documentation that they have put in the medical record?

MR. KNOTT: Form, vague, and overly broad.

A That would depend nurse to nurse to doctor to doctor to venue. That depends.

Q (By Ms. Irene, continuing) So you're saying there is venues where it would not be important for the physician to read the documentation that nurses put in the medical record?

A No, that's not -- that's not what I said. You asked if it was -- that nurses -- I don't recall exactly how you asked it, but expected the physician to look at it, something to that. And no, that's not always the situation.

The example I gave you for telehealth, that

physician on the other side of the screen may not see that nurse's documentation. That's a verbal discussion and observation working with the patient over the screen. The nurse is not expecting the doctor to ask for her nurse's note to send it over necessarily.

So there are definitely venues and situations where that's not the case.

MS. IRENE: Okay. I think now would probably be a good time to take a break.

MR. KNOTT: Sure.

THE VIDEOGRAPHER: All right. We're off the record at 11:25.

(Off the record)

THE VIDEOGRAPHER: We are back on the record for the deposition of Kim Pearson being conducted by videoconference. Today is February 26, 2025, and it is 11:32 a.m. Central.

Q (By Ms. Irene, continuing) Ms. Pearson, did you form an opinion in this case about the standard of care provided by Nurse Fennigkoh?

A Yes.

Q Did you form an opinion in this case about the standard of care provided by ACH?

MR. KNOTT: Object. It's vague and overly broad.

A Yes, in that the service -- their services are reflected in Nurse Fennigkoh's care and actions.

Q (By Ms. Irene, continuing) Did you form an opinion in this case about the standard of care provided by ACH outside of Nurse Fennigkoh's actions -- Nurse Fennigkoh's care and actions?

MR. KNOTT: I think that's vague and overly broad.

A Well, I don't know how to separate the two. She's employed by ACH, so.

Q (By Ms. Irene, continuing) I guess what I'm asking is, did you form an opinion in this case about the standard of care provided by ACH in anyone else's cares and actions?

For example, in Nurse Pisney's care and actions?

A No, I was not --

MR. KNOTT: Object. Vague. But if you want to answer the question with respect to Ms. Pisney, go ahead.

A I was not asked to review this matter related to Nurse Pisney.

Q (By Ms. Irene, continuing) Do you know when Ms. Boyer was initially booked in the Monroe County Jail?
A Yes.
Q And when was she booked?
A December 21st of 2019.
Q And can I ask, I see you looking down slightly, are you looking at a document?
A My report.
Q Okay. Just because I'm not there with you, in the future, if you are looking at a document to help answer a question, if you could let me know what document you're looking at, that would be --
A I guess I have to refer to my report because I don't have all of the dates and times memorized.
Q Oh, yes. No, of course. Refer to your report. It's just because we're not in person --
A Sure.
Q -- otherwise I'd be able to see what you're looking at, and then I could look at it too. Just let -- yes. So if you -- I understand you have your report in front of you now. If you switch off or start looking at something else, if you could just let me know.

A No problem.

MR. KNOTT: So just so I'm clear, you want her to tell you if she's looking at something other than her report?

MS. IRENE: Yes. If she's -- if she's looking at another document or something that's in front of her that she's using to rely upon to give her answers.

MR. KNOTT: Okay. Because I don't want her to interrupt her answer every time she looks down in order to let you know, so.

Q (By Ms. Irene, continuing) Yes. To be clear, you do not -- I understand that you're looking at your report. You do not need to say every time I'm looking at my report. Just if you move on to something, some other different document other than your report.

A Okay.

Q Who was the medical professional who first interacted with Ms. Boyer?

A Based on my review of the records it would be RN Fennigkoh.

Q And what was Nurse Fennigkoh's interactions with Ms. Boyer -- or first interaction with Ms. Boyer?

A Well, when she came into the jail.
Q Did Nurse Fennigkoh do an intake screening for Ms. Boyer?
A No, she did not do the intake screening document. That's done by custody. So she interviewed Ms. Boyer and wrote a nurse's note.
Q And during Nurse Fennigkoh's interview with Ms. Boyer, what did Ms. Boyer say?
MR. KNOTT: Object. It's vague and overly broad.
A Well, we would need to pull up the note. It's -- she -- RN Fennigkoh wrote what Ms. Boyer said. I can't tell you verbatim without looking at it.
Q (By Ms. Irene, continuing) Sure. One moment. Sorry, I'm just going to share my screen.
MR. KNOTT: I think it's Exhibit 6.
MS. IRENE: Yes, I think.
Q (By Ms. Irene, continuing) Ms. Pearson, is this the note that you're referring to?
A Yes.
Q So is this the narrative note?
A Yes. I'm sorry, I probably called it a nursing note, but it's a narrative note.
Q I'll mark this as Plaintiff's Exhibit 4.
MR. KNOTT: Previously marked as

Exhibit 6.

MS. IRENE: Thank you.

Q (By Ms. Irene, continuing) So during Ms. -- or Nurse Fennigkoh's interview with Ms. Boyer, was Nurse Fennigkoh informed by a corrections staff officer that Ms. Boyer was a medical mess?

A I -- that's not my understanding based on what's written. There was a Tomah PD officer who made that statement, not a correctional officer, according to the note.

Q Yes, thank you. And what did -- what were some of the medical concerns that Ms. Boyer relayed to Nurse Fennigkoh?

A Do you want me just to read it to you?

Q Sure.

A Okay. So Nurse Fennigkoh wrote, patient states I only have one year to live. Nurse Fennigkoh asked for further clarification. Ms. Boyer stated, in quotes, I have all my organs shutting down. Radiation back then did me in. I don't have a hip. I pee myself and shit myself every 20 minutes. I am peeing right now.

Additional questions were asked by Nurse Fennigkoh. Ms. Boyer stated, in quotes, what's it matter to you. Also stated I have had bone

cancer, blood cancer, three pelvic surgeries, three bladder lifts, three abdominal surgeries, do you want me to continue.

She also reported to -- she stated to Nurse Fennigkoh, my husband doesn't know where my medication is. I hide it from him. He doesn't have a clue what I take. And she said she would call him regarding the medications.

Q Did Ms. Boyer say if she was on any medications?

A She indicated she was on a blood pressure med and oxycodone and other meds, but did not elaborate.

Q On this narrative note where it says PT, do you know what PT stands for?

A Patient.

Q And was Ms. Boyer intoxicated at the time of this interview?

A Yes, that is my understanding.

Q What is PBT?

A PBT?

Q Yes.

A I believe -- I can't tell you what the letters are. I believe that's the test that custody uses to determine blood alcohol level. It's a

custody --

Q Oh, I'm sorry. Were you finished?

A Yeah, just custody test. It's not something medical is involved in.

Q And was Ms. Boyer's blood alcohol level .133?

A Well, that's what's documented.

Q And is that a high blood alcohol level?

A Well, I don't know Wisconsin's number. I'm assuming since -- it's not -- how would I answer that. I mean, she's in the jail, and but it does not reach the level of blood alcohol high enough that she needs to be sent out to the hospital.

Q Okay. And did Ms. Boyer say where she got her medications in the interview?

A Yes, she did. Tomah Medicine Shoppe.

Q And did Ms. Boyer have any medications on her?

A She had some loose pills in her purse.

Q And were those pills able to be identified?

A Some of them.

Q And what were the ones that were able to be identified identified as?

A I would need to look at the verification sheet as to which ones were identified. They were not all identifiable.

Q In her narrative report -- or narrative note did

Nurse Fennigkoh write what medications she found on Ms. Boyer?

A Yeah. Actually, she did. She wrote ondansetron, aspirin, oxycodone, and other identified -- broken unidentified pills were found.

Q What is ondansetron?

A I believe that's Zofran for nausea.

Q One moment. Ms. Pearson, do you know what this is?

A Intake medical screening report.

Q Is it the intake medical screening report for Christine Boyer?

A Yes.

Q Did you review this?

A Yes.

Q At her intake screening did Ms. Boyer state that she had one year to live?

A They quoted her here as saying some doctors say I have a year to live.

Q And at the top of this --

MR. KNOTT: For the record -- I'm sorry to interrupt. But for the record, the intake medical screening is Exhibit 3 to the case, just for the record.

MS. IRENE: Yes, thanks. And I guess

I'll mark this Plaintiff's Exhibit 5 for this deposition.

MR. KNOTT: You actually don't need to, but -- and we were also going in sequence. We could try to sort that out at a break, but just keep going. Do whatever you want to do, Madison. I'm sorry.

MS. IRENE: No, thanks. That's helpful.

Q (By Ms. Irene, continuing) And, Ms. Pearson, at the top of this form where it says PBT per, we said PBT and then it says -- sorry, I'll withdraw that question.

Ms. Pearson, at the top of this form it says PBT .133. That is blood alcohol content; right?

A Yes. That's my understanding.

Q And then next to PBT .133 it says per and then the numbers 1294.

Do you know what those numbers 1294 mean?

A I do not definitively know, but I will tell you in my experience working in correctional settings that officers typically sign with their assigned number versus a name. So it -- that would be logical to me, but I can't unequivocally tell you

that.

Q Did Ms. Boyer stay -- or say in her intake screening if she had taken blood medication that day?

A If she had taken what?

Q Blood pressure medication that day?

A Oh, yes. It's written that she did take it that day.

Q And was Ms. Boyer on any type of special diet?

A When she was asked that question she said whatever I can keep down. Also said she was -- could not have peanuts or seeds due to her bowel.

Q And is it your opinion that Ms. Boyer's intoxication made it difficult for her to answer questions about her medical history?

A Is it my, did you say opinion or impression? Could you restate the question or reask the question?

Q Yes. Sure. I asked for your opinion, but it could also be your impression, that Ms. Boyer's intoxication made it difficult for her to answer questions about her medical history.

A Well, based on the note that RN Fennigkoh wrote, she definitely was not forthcoming, often

wouldn't answer, it was difficult to get information.

And I believe that was -- Sergeant Warren I believe had testified in her deposition of that fact as well, that it was difficult to get good information, get her to answer questions.

Q And on page 9 of your report, we had in this deposition I believe previously marked this as Plaintiff's Exhibit 3, sort of in the middle of page 9, do you say that it's often challenging to obtain a clear and accurate medical history from intoxicated individuals newly booked into any jail facility.

A Yes. I wrote that.

Q Can you tell me more about your experiences with that. I'll withdraw. I can clarify.

Can you tell me more about in your experiences the difficulties that you've had with taking intake from intoxicated individuals who are newly booked into a jail facility.

A Sure. It's, as I said, it's challenging, often challenging to obtain clear and accurate medical information. You get vague information. You get partial information, incomplete information. And oftentimes people are -- they don't want to

cooperate and so they just won't answer questions. I mean, it varies.

It's about 69 to 70 percent of the individuals coming in county jails have one or more substance use issues, and so this is a very prevalent population in the jails that we're accustomed to working with. And it's just -- it's just known that it's -- it's difficult at times when someone's intoxicated to get those answers and you -- you just have to keep that in mind.

Q Would Ms. Boyer's blood alcohol content have been lower by the following morning?

A That's outside of my scope of expertise.

Q You agree that someone is more likely to be able to accurately relay information when they are sober than when they are under the influence of drugs or alcohol?

A That's quite possible, yes.

Q Is there any situation that you believe that not to be true?

A Well, you know, again, it depends on the individual. Theoretically, you should be able to get clearer, more accurate information if they're not intoxicated. But you're also then, what else

is going on. Do they have a medical issue. Do they have a mental health issue. Do they just not want to cooperate. I mean, there's all kinds of scenarios there, but.

Q Okay. So to clarify, holding all other factors constant, do you agree that it's more likely to be able to accurately -- or accurately relay information when patients are sober than if they are under the influence of drugs or alcohol?

A I think it's more likely. It's not a given. Because again, you're dealing with patients -- I've dealt with hundreds and hundreds of patients who could not relay their history to me clearly. Didn't even know, you know, I'm on a blue pill. I'm on a white pill. So it really depends on the individual.

But yes, in theory, if you're not intoxicated you would like to think that perhaps you would get better, clearer information.

Q So do you have experiences with patients who are able to better relay information to you while they were under the influence of drugs or alcohol than when they were sober?

A I don't know that I can come up with any examples of that.

Q Do you have any experiences that you remember personally with patients who were better able to relay information to you when they were on drugs or alcohol than when they were sober?

A Yeah, I can't think of any situations off the top of my head.

Q Do you agree that it would have been possible for Nurse Pisney to get another medical history from Ms. Boyd (sic) the following day?

MR. KNOTT: Object to the form of the question.

A I did not review this case in terms of Nurse Practitioner Pisney.

Q (By Ms. Irene, continuing) Okay. Do you agree that it would have been possible for Nurse Fennigkoh to get another medical history from Ms. Boyd the following day?

MR. KNOTT: Object to the form of the question.

A Well, Nurse Fennigkoh wasn't on duty the following day.

Q (By Ms. Irene, continuing) Was Nurse Fennigkoh at the jail the following day on Sunday, December 22nd?

A Yes, she was there late in the afternoon for a

one-patient assignment, not in her role as an ACH nurse providing the care she typically provided with ACH on a regularly scheduled day.

Q I understand that, Ms. Pearson, but would it have been possible for Nurse Fennigkoh to get another history from Ms. Boyd while she was there the following day?

MR. KNOTT: Object to the form of the question. It's asked and answered. Vague and overly broad.

A Well, it's just not even -- it's not even relevant. The intake screening was done by custody on Saturday night, Saturday night/Sunday morning.

And Nurse Fennigkoh -- there would not have been any reason for Nurse Fennigkoh to act outside of the scope of what she was there to do that particular day to do that.

Q (By Ms. Irene, continuing) Ms. Pearson, I think -- I understand that you don't believe it to be relevant, and I understand that you do not think that there was a reason for Nurse Fennigkoh to do so.

But what I'm asking you is if you -- is if it was possible for Nurse Fennigkoh to speak to

Ms. Boyer again about her medical history on that day?

MR. KNOTT: Object. Asked and answered. Foundation. Calls for speculation. Vague and overly broad.

A It just is not part of the process that's in place. Intake screening is done at the time of intake. That's one component of correctional health care, and then we move forward and there are other avenues to get further information.

Intake screening is a snapshot at that point when they come in to identify urgent and emergent issues. So it's not part of -- it just is not something that would be done. It's not standard of care by any means to go back and do an intake screening at that point.

Q (By Ms. Irene, continuing) Ms. Pearson, I'm sorry, but I have to ask you this question again. I'm not asking if it was part of the process. I'm not asking if you believe it was standard of care. I'm asking -- I'm asking you if it was possible for Nurse Fennigkoh to do so?

MR. KNOTT: Object to the form of the question. It's vague and overly broad.

A I don't know. I don't have an answer.

Q (By Ms. Irene, continuing) What information to that question would have helped you to be able to answer this question?

MR. KNOTT: It's vague. Overly broad.

A Well, it just -- it doesn't make sense. It's, again, the intake screening is at intake, and then there's other healthcare that follows. And so -- this is the flow in any jail. Then additional information is gathered. Not in an intake screening. And as in this case, additional information is gathered, discussions with the nurse practitioner. That's just the flow.

It's just not -- you don't go backwards. And it's like at a hospital. You don't go re-admit someone 24 hours later. They're already admitted. You keep moving forward in gathering information.

Q (By Ms. Irene, continuing) Okay. Do you agree, based off the variety of things that Ms. Boyer said about her health conditions during her interview with Nurse Fennigkoh and during her intake screening, that she could have had any number of different medical conditions?

MR. KNOTT: Object to the form of the

question.

A She could have had medical conditions she did not disclose, and then she stated several things that she had undergone in her lifetime.

Q (By Ms. Irene, continuing) Do you agree that even with the things she did disclose that she wasn't specifically clear in what her conditions were?

A Yes. I mean, she wouldn't answer all of the questions fully. And you never know if a patient is fully forthcoming or not. You don't know. You just have to take down the information -- the information they provide, along with your observations, and continue to move forward.

It's the same in the emergency department. Patients come into the emergency department and they tell you what they choose to tell you. There's no way to know if they're fully telling you everything about their condition.

Q And for Ms. Boyer, did a corrections officer complete Ms. Boyer's intake medical screening?

A Yes. That's my understanding.

Q And are corrections officers trained medical professionals?

A In general I would say no. There are some that are. But in general, no.

Q Are intake screenings an important step in patient care?

MR. KNOTT: Form. It's vague.

A Yes. Intake screening is the first step when someone arrives at the jail to try to identify if they have any emergent or urgent needs in terms of their healthcare.

Q (By Ms. Irene, continuing) Sorry. I just want to -- I just want to be clear. You said that intake screenings are the first step.

I'm asking if you believe intake screenings are an important step to patient care?

MR. KNOTT: Vague and overly broad.

A Yes. It's information that we desire to have when someone comes into a jail.

Q (By Ms. Irene, continuing) And why is it information that you desire to have?

A Well, again, the point of the intake screening is to identify any emergent or urgent medical needs that the patient may have as well as identifying other healthcare issues that need perhaps further investigation, more information. And we're also wanting to make sure we don't have someone with a contagious disease. That helps us figure out where to house those people.

Q At her intake screening did Ms. Boyer report having congestive heart failure?
A Not to Nurse Fennigkoh. But I believe -- I'd have to see the intake screening form again. But not to Nurse Fennigkoh.
Q One moment. Okay, Ms. Pearson. I'm just going to reask the question.
At her intake interview, did Ms. Boyer report having congestive heart failure?
MR. KNOTT: Object to the form of the question. It's vague.
A It's -- I'm sorry.
Q (By Ms. Irene, continuing) You can answer, Ms. Pearson.
A It's documented that she stated she had congestive heart failure to the officer.
Q And did she say that she had health problems from chemo and radiation?
A It's documented that she stated she had medical issues due to chemo and radiation.
Q And did she report having asthma?
MR. KNOTT: Object to the form of the question.
A Could you scroll up, please, one page.
Q (By Ms. Irene, continuing) Yes.

A It is circled that she reported having asthma.
Q Was Nurse Fennigkoh aware that there would be no medical staff left to provide care for Ms. Boyer after she left?
MR. KNOTT: Vague.
A Well, I believe Nurse Fennigkoh was aware that there was not a nurse coming in for the overnight shift.
However, there was healthcare available in that the nurse practitioner was available 24/7 on call. And Nurse Fennigkoh further directed custody to contact the nurse practitioner, as they would. This was a process they had in place.
Q (By Ms. Irene, continuing) So after Nurse Fennigkoh left, ended her shift, there was no other medical care professional on site at the jail?
A I -- yes, I believe that's accurate. There was not a nurse following her. It was the 24/7 on-call provider available.
Q Did Nurse Fennigkoh give Ms. Boyd medical clearance?
A Could you restate that in a different way?
Q Sure. Did Nurse Fennigkoh give Ms. Boyd medical

clearance for a physical assessment to be done by a practitioner?

MR. KNOTT: Object to the form of the question. I think it's vague.

A Well, nurses -- I can't answer -- no, because nurses don't give medical clearance to allow a practitioner to evaluate. That's -- it's not a --

Q (By Ms. Irene, continuing) Sorry, were you finished?

A Well, it's just not a -- that doesn't exist.

Q Okay. And did Nurse Fennigkoh recommend that Ms. Boyer be taken to the hospital at any time?

MR. KNOTT: Recognize? Object to the form of the question.

A No, I do not believe that she recommended her going to the hospital if she did not have an urgent or emergent need necessitating that.

Q (By Ms. Irene, continuing) Do you know if Nurse Fennigkoh ever wrote down Ms. Boyer's vital signs?

A I do not believe she did.

Q Do you know if Nurse Fennigkoh initiated a withdrawal screening?

A No, she did not.

Q Can patients who have significant medical conditions be affected by withdrawal differently?

MR. KNOTT: Object to the form of the question. Foundation. Vague.

A That's outside my scope.

Q (By Ms. Irene, continuing) Looking at question No. 3 on Ms. Boyer's intake medical screening the question says, are you or will you be experiencing alcohol or drug withdrawal?

Do you agree with me that this question asks the patient to self-assess whether or not they will be experiencing withdrawal?

A Yes, I agree with you in that -- two things. One is, that is what an intake screening is. It's a structured inquiry asked to the patient to get information from the patient.

There are many, many people who cycle in and out of jails who cycle on and off of drug use who experience withdrawal, they know they're going to experience withdrawal, they know what it feels like, and that's pertinent information. Again, that's the subjective component. And then we have the objective -- the objective observations that healthcare can look at as well.

So this is just one piece of information

that is very important for a patient. It's very helpful, especially when a patient has had withdrawal and they say yes, I've had withdrawal. That's very important information for us.

Q Are there patients who may not know if they're going to experience withdrawal?

A Yes, there are.

Q And do you agree with me that this question does not ask, for the patients who have experienced withdrawal, what their withdrawal symptoms have been in the past?

MR. KNOTT: Madison, could you restate that again?

MS. IRENE: Yes. Yes.

Q (By Ms. Irene, continuing) Do you agree with me that this question does not ask, for the patients that have experienced withdrawal, that this question does not ask what those withdrawal experiences have been in the past?

MR. KNOTT: Object to the form of the question. It's beyond the scope of the opinions. Foundation.

Go ahead.

A Yes. The question is asking if they've experienced -- are you currently or have you

been, will you be experiencing withdrawal. It doesn't go into the details of withdrawal.

Q (By Ms. Irene, continuing) The question does not ask about previous withdrawal symptoms?

A Well, again, it's will you be experiencing, as I described before. Because when people have experienced withdrawal, they are likely to tell you yes, I will be experiencing withdrawal based on I have experienced withdrawal. I mean, that's just logical.

Q Yes, but are there different -- do people have different withdrawal symptoms?

A They do have different withdrawal symptoms. However, those withdrawal symptoms in general are, you know, there's 8, 9, 10, 11. It depends on which substance we're talking about that are the most common.

And so not everyone experiences -- everybody's withdrawal is different, and not everyone experiences the same. And most people don't even experience all of the most common.

Q And does this question, question No. 3, ask people to explain what their withdrawal -- their previous withdrawal symptoms have been?

A No. It's an intake screening. And so if they

answered yes, then as -- if a withdrawal monitoring were going to be instituted, totally separate piece of paper, totally separate issue, then those things would be discussed at a different time.

This is an intake screening. Snapshot in time. We're trying to gather emergent/urgent information.

Q Do you agree that practitioners should be conducting assessments to ascertain if a patient is experiencing withdrawal symptoms?

A Well, they asked her. She said no. There was no observation of objective information that led -- would lead a reasonable clinical provider to believe she was in withdrawal. So at this point in time there's -- this has been answered.

As days, hours evolve, I mean, this is part of -- if someone -- let me put it this way. People come in and they say they're not using drugs. And then two days later they contact medical and say I'm in withdrawal and they didn't report it to us at the time. So immediately at that point we institute what needs to be done at that point.

Withdrawal, these are just the first

questions at intake, and then it can expand from there if it's clinically indicated.

Q Aside from a patient saying that they are experiencing withdrawal, what are indicators that someone may experience withdrawal?

MR. KNOTT: I think the question is vague and overly broad. Could we specify alcohol, drugs --

MS. IRENE: Yes.

MR. KNOTT: -- anything else and the circumstance?

Q (By Ms. Irene, continuing) Sure. Can increased blood alcohol levels indicate a risk of withdrawal?

A Well, perhaps. But again, it depends on the situation. Someone who goes out to a party and gets intoxicated and comes in with a high blood alcohol level but doesn't drink in general, that blood alcohol level is not indicative of the fact that they're going to go into withdrawal. That's a one-time thing.

So again, it depends on the situation, it depends on the patient, and their history.

Q Yes. So, Ms. Pearson, to be clear, I'm not asking if in every case increased blood level --

if increased blood level -- sorry. Let me withdraw that question.

Ms. Pearson, I'm not asking if in every case increased blood alcohol levels are indicative of withdrawal. I'm asking if increased blood alcohol levels can be indicative of a risk for withdrawal?

MR. KNOTT: Asked and answered and vague, but go ahead.

A I don't think in and of itself that one number alone would -- it depends. It depends. It depends on how high that level is. Is this a patient we know. Have they been in before. Have we seen this before. There's so many variables.

Q (By Ms. Irene, continuing) Okay. If a patient is filling out an intake screening while intoxicated, are their answers less likely to be reliable than if they were sober?

A Okay. Well, patients don't fill out intake screening forms. These are questions that are asked by staff to the patient.

And if someone is intoxicated, and someone who's not intoxicated, frankly, we're only going to get as good of information as they are able

and willing to provide.

Q And when a patient is answering questions to an intake screening form while intoxicated, are their answers less likely to be reliable than if they were sober?

A That's possible.

MR. KNOTT: Object. But go ahead.

A It's possible they may not provide as accurate or clear of answers.

Q (By Ms. Irene, continuing) And looking at question 13 on this form, do you abuse alcohol or drugs, which kinds of alcohol or drugs and how often do you use them, do you agree that this question does not ask the patient if they know what symptoms they have or may experience with withdrawal?

A Well, no, it doesn't ask withdrawal questions. It's not the withdrawal question. This is a different question. This is just asking if they abuse alcohol or drugs and what kind. The withdrawal question was on the previous page.

Q In your opinion, are individuals who misuse substances typically accurate in their description of their pattern of substance abuse?

A Well, I can't definitively answer that question because only the patient's going to know. I mean, if they say they use a half a gram of heroin a day, that's what I would document. But I don't -- I don't know that. They could be completely accurate. I don't know.

Q Do you have experiences where patients over- or underestimate their drug use?

A Well, again, I don't know, because I'm not with them other than in that snapshot of time.

Q How does this intake screening compare to others that you've seen in some of the places that you've worked?

MR. KNOTT: It's vague and overly broad.

A Well, intake screening reports -- intake medical screening reports are -- they're all very different in the order of questions.

But in terms of content, it does ask the questions that we would expect -- we would want to ask when an individual comes in at that point.

Q (By Ms. Irene, continuing) Is this intake medical screening report less thorough than others that you've seen?

MR. KNOTT: Vague and overly broad.

A No, I wouldn't say it's less thorough. Again, it's different order. Different questions are asked a little bit differently. But the content and the intent of what we're trying to find out is on the form.

Q (By Ms. Irene, continuing) One moment.

A I believe -- I believe I outlined all that in my report in terms of what's required by NCCHC and where it's found, on what question in the intake screening.

Q You may have outlined. I may be asking you questions about things that you have already said in your report. But I just have to ask you them sometimes just for my own clarification so I can get a better understanding.

A Sure.

Q Okay. I'm going to share my screen with you again. I'm now showing what's been Bates marked Monroe County 000088.

Do you recognize this?

A Yes.

Q Did you review this?

A Yes.

Q Is this an email that was sent by Nurse Fennigkoh?

A That's what it states, yes.
Q And was this email -- who was the email sent to?
A Danielle Warren, Lucas Runice, Shasta Parker, Kyle Moga, Ryan Hallman, and Stan Hendrickson.
Q And when was this email sent?
A December 22nd of 2019 at 6:02 p.m.
Q And what does this email say? Or I guess I'll withdraw that question.
In this email does Nurse Fennigkoh convey that Ms. Boyer's husband had called -- that she had taken a call from Ms. Boyer's husband?
A Yes.
Q And on that call did Ms. Boyer's husband indicate that he would be bringing medications for her?
A Yes.
Q And did Ms. Boyer take this call while she was at the jail on Sunday, December 22nd?
A Yes.
Q And did she take it while she was there for -- while she was there for the purposes of seeing a different patient?
A Yes and no. Yes, she was there to see the one patient. And she had clocked out and yet took this call because the phone rang after she had

clocked out and was getting ready to leave.

MR. KNOTT: For the record, that was Exhibit 9 previously marked.

MS. IRENE: Thank you.

Q (By Ms. Irene, continuing) What happened after Ms. Boyer completed her intake screening?

MR. KNOTT: Object to the form of the question. It's vague and overly broad.

A In terms of what?

Q (By Ms. Irene, continuing) Sure. So what happened -- do you remember Ms. Boyer complaining to custody staff about feeling hot and sweaty?

A Okay. We're not talking about after -- we're on a different topic now? Not after an intake screening?

Q Oh, I'm asking, do you remember her saying that she was hot and sweaty after the intake screening?

MR. KNOTT: It's vague as to time.

A No, after the intake screening she was placed on medical observation and monitored by officers all night on Q 30 minutes or more checks, and there were -- she had no concerns and no issues after the intake screening over the course of the night.

Q (By Ms. Irene, continuing) Ms. Pearson, if you can look at -- hang on, I'll share my screen again -- your report on page 10, and sort of the middle of the page where you say at some point prior to 4 p.m. Ms. Boyer had complained to custody staff of feeling hot and sweaty, difficulty breathing, and requesting that her blood pressure be taken.

Are you referring to -- is that you referring to Ms. Boyer at the intake screening?

A No. If you go back to page 9, the bottom paragraph, this is a timeline chronology and order of what happened. We're on Sunday, 12-22 --

Q Okay. So --

A -- at 4 p.m. So this is far beyond the intake screening.

Q My apologies. Okay. So after the intake screening Ms. Boyer did complain to custody staff of feeling hot and sweaty?

MR. KNOTT: Object to the form of the question. It's vague as to time. This is asked and answered. And I think you need to be specific as to a time frame.

A Yeah, the intake screening was on Saturday, the

21st, in the, you know, 11:30 time range. And this is now Sunday, the 22nd, 4 p.m. So that's what this note is about. It's not -- I mean, it's sometime later. How many hours that would be, 16 hours later.

Q (By Ms. Irene, continuing) Okay. So -- sorry. Ms. Pearson, when you write in that paragraph that at some point prior to 4 p.m. Ms. Boyer had complained to custody staff of feeling hot and sweaty, do you know what time she made that complaint?

A Yes. I believe that was approximately around 3 p.m.

Q And was it around that time where Ms. Boyer also complained of having difficulty breathing?

A There are some notes to that effect, and then there's some -- yes, that she complained about that, but Parker's deposition testimony stated she didn't observe that. She didn't seem to have any difficulty breathing.

Q And was it also around that time, 3 p.m., that Ms. Boyer requested that her blood pressure be taken?

A Yes. That's my understanding.

Q Was Ms. Boyer's oxygen saturation taken?

A I don't recall. I would need to look at the records. I would need to look in the records.

Q Is -- what document in particular would you need to look at?

A I don't know if it's -- I just don't recall if it's documented on the illness reports or not.

Q Is oxygen saturation a vital sign?

A It can be considered a vital sign.

Q What is oxygen saturation?

A The saturation of oxygen in the blood.

Q And why could it be considered a vital sign?

MR. KNOTT: Object to the form of the question.

A I'm not sure how to answer that question. It's sometimes obtained with other vital signs. Sometimes not. It's a piece of data.

Q (By Ms. Irene, continuing) Is it an important piece of data?

MR. KNOTT: Object. Vague. Overly broad.

A It depends on the situation.

Q (By Ms. Irene, continuing) Are vital signs important pieces of data?

A Are they what?

Q Are vital signs important pieces of data?

A Yes, they can be. It depends on the situation.
Q Are there situations where vital signs are not important pieces of data?
A So in healthcare we have some scenarios that we call focused assessment. So rather than doing a full head-to-toe history of someone's entire medical life, let's use an example, I'm just giving you an example of you're at a half-marathon medical tent and somebody fell and they've got an open fracture. Okay, they're dealing with a fracture. It's a focused assessment. They're dealing with the immediate urgent issue at the time.

So vital -- vital signs are pieces of information, absolutely, and they can be very, very helpful. But they're not always obtained in every -- every healthcare encounter because they're not clinically necessary in every clinical encounter.

Q Do you know if Ms. Boyer's respiratory rate was taken?

MR. KNOTT: Form.

A I believe that -- I believe there was some documentation by the officers on one of the illness reports about a respiratory rate.

Q (By Ms. Irene, continuing) And just so I'm clear, when you say "illness reports", what documents are you referring to?

A I believe they're called illness reports. It's the form that custody uses to document a patient's healthcare concerns, and then as in this situation made a call to Nurse Practitioner Pisney and documented on that form about that call.

Q Okay. One moment.

A Actually, I'd like to add to my previous answer about oxygen saturation. I just was -- flipped the page in my report, and I documented in my report that her oxygen saturation had been taken, so.

Q Okay. So to my question was Ms. Boyer's oxygen saturation taken, your answer is now yes?

A It is, yes.

Q Actually, sorry. It's too late to withdraw that, but let me just reask the question.

Was Ms. Boyer's oxygen saturation taken?

A Yes.

Q When was Ms. Boyer's oxygen saturation taken?

A Well, again, I would need to go back and look at all the records. I'm just looking at one line

item in my report, and it was during the time when custody staff completed the illness report at 8:53 in the evening, and it's documented on there. It may be other places as well. I just don't recall without pulling up the records.

Q Was Ms. Boyer's heart rate taken?

A Yes.

Q Is heart rate a vital sign?

A Yes.

Q And, sorry, I'm going to share my screen again. Ms. Pearson, I'm showing you the Medication Administration Record for Ms. Boyer.

Have you seen this before?

A Yes.

Q Did you review this?

A Yes.

Q Is this one of the things that you were talking about as being part of the illness report?

A No.

Q Okay. On Sunday, December 22nd, did Officer Shasta Parker speak with Nurse Pisney?

MR. KNOTT: Form.

A I'm -- I just need to look at my report because I don't even know if I wrote which officer spoke to Nurse Pisney, but I may have written custody

called. I'm just not sure which one without really going through my report and see if I even noted that.

MR. KNOTT: Madison, are you referring to Nurse Practitioner Pisney or Nurse Fennigkoh?

MS. IRENE: I am asking about Nurse Practitioner Pisney.

MR. KNOTT: Okay. Thank you.

Q (By Ms. Irene, continuing) And yes, Ms. Pearson, please take however long you need to look over your report.

A Well, again, I don't know that I would have specified which officer called the nurse practitioner. I know -- I know Parker was on duty.

But again, if we want -- if we want to pull up records, I can start to try to figure that out. But I know Custody did contact Nurse Practitioner Pisney, absolutely.

Q And do you know why officers contacted Nurse Practitioner Pisney?

A Well, again, it was this issue of Ms. Boyer asking to have her blood pressure taken, and her blood pressure was elevated and so they contacted

Nurse Practitioner Pisney.

Q And did Nurse Practitioner Pisney give any instructions as to how to help treat the blood pressure concerns?

A Yes. She gave instructions in terms of medication administration, blood pressure rechecks and parameters to call her back.

Q Did Nurse Pisney instruct to give a dose of Clonidine -- I'm not sure if I'm pronouncing that right -- to Ms. Boyer and then to recheck her blood pressure at 3:45?

A I know that she -- let me preface my answer by saying again I was not asked to review Nurse Practitioner Pisney's care, clinical orders, outside of my scope.

So yes, I reviewed the timeline and the things that she did, but I don't have all of that committed to memory.

I do know, to answer your question, she did order a dose of Clonidine and she did order a blood pressure recheck again with parameters provided for them to call back.

Q And do you know if Nurse Pisney left instructions on what to do if Ms. Boyer's blood pressure was still high after five o'clock?

MR. KNOTT: Form. Scope. Foundation.

A Yeah, I don't know about five o'clock. This was an ongoing conversation. So I know that an additional dose of Clonidine was given and additional recheck done. That's documented in the record.

Q (By Ms. Irene, continuing) And do you know if after that second additional recheck if Nurse Pisney left any instructions for what to do after that second check if Ms. Boyer's blood pressure was still high?

MR. KNOTT: Form.

A Well, it wouldn't -- it wouldn't work that way, so she would have given the instruction before. So it would -- she would say give this Clonidine, recheck the blood pressure, and if it's, whatever her parameters were, if it's below those parameters -- or call me back if it's above those parameters. And so if it's not, if it's below those parameters, then there's not a need to call back.

Q (By Ms. Irene, continuing) Do you know what a hypertensive crisis is?

A Yes.

Q Is a hypertensive crisis when systolic pressure

is over 180 and/or diastolic is over 120?

A You know, that's outside of my scope in terms of the current definition.

Q Okay. One moment. I'm going to share my screen again.

A Have I missed a question?

Q I apologize. I forgot to take myself off of mute.

Ms. Pearson, have you seen this before?

A Yes, I have.

Q Did you review this -- have you reviewed this document before?

A Yes, I have.

Q And is this an email that was sent from Shasta Parker?

A Yes, it is.

Q And did Shasta Parker send this email to a jail nurse email?

A Well, there is an email address that says jail.nurse@co.monroe.wi.us.

Q And is one of the people cc'd on this email Amber Fennigkoh?

A Yes.

Q And in this email does Sergeant Shasta Parker say that Ms. Boyer was complaining of feeling hot and

sweaty and not being able to breathe?

A Yes.

Q And does she say that -- does Officer Parker say that Ms. Boyer's blood pressure was really high?

A That's what she wrote.

Q And at the bottom of this email did Officer Parker say that she wanted to make sure that -- did Officer Parker say she wanted to make sure you were aware for follow-up purposes, if necessary?

A Yes.

Q Do you know why Sergeant Parker would have sent this email to Amber Fennigkoh?

MR. KNOTT: Form. Foundation.

A Well, she actually sent it to the jail nurse email. So I don't know who the other nurses are who work there, but so Amber is cc'd on that. But this is just a great communication, frankly, just to provide information to the nursing staff when they are back in the building.

All of this information is in the record, but she went over and above here and just provided a quick email with an overview of what occurred.

Q (By Ms. Irene, continuing) Yes. My apologies.
My question should be, do you know why Amber Fennigkoh was cc'd on this email?
A No. I don't know -- I would have to speculate, but I don't know. I don't believe that Shasta Parker testified about why she included her. But obviously, they had had conversations.
Q In your experience with updates, with health updates like this in a correctional facility, are you aware of any type of protocols for who to cc on health update emails?
A I don't -- the health information is in the medical record. This is just an additional communication. It's not to take the place of the record. It's just an additional communication.
Q Is there anything that you believe Nurse Fennigkoh could have done differently?
MR. KNOTT: Object. The question is vague and overly broad.
A In regard to something specific or?
Q (By Ms. Irene, continuing) Is there anything that you believe Nurse Fennigkoh could have done differently to provide better care for Ms. Boyer?
A No. No. Nurse Fennigkoh exceeded the standard

of care, frankly. She -- she was off duty, had clocked out at 9:30 on Saturday night and stayed off the clock to assist with interviewing and asking questions to Ms. Boyer.

And she placed her in medical observation. She initiated medical observation. She did a referral to mental health just because she felt Ms. Boyer was stressed and had mental health take a look at her. And she contacted -- she talked with the husband. She tried to get medication information. Tried to get diagnosis information. Sent emails to staff saying the husband's coming.

When he arrives with the information, which didn't happen until 1 in the morning-ish, she said whenever he gets there, call Nurse Practitioner Pisney with this information.

I mean, she did everything that she could do within her scope and licensure and went over and above. She fielded a phone call at six o'clock after she had clocked out at 5:30.

I mean, she's -- it's evident she is dedicated to her patients and was trying to do what she could for Ms. Boyer.

Q Did you -- did you form an opinion about the adequacy of the chest pain protocol form used in

this case?

A No. No, I did not.

Q Did you form an opinion in this case as to the lack of morbidity and mortality reviews by ACH in this case?

MR. KNOTT: Object to the form.

A I did -- I was asked to review Nurse Fennigkoh's care and treatment.

Q (By Ms. Irene, continuing) So I'm sorry, I'm just going to ask again.

So did you form an opinion in this case about the lack of morbidity and mortality reviews by ACH?

MR. KNOTT: Form.

A I did not form an opinion in any way about the presence or lack or anything about a mortality review.

Q (By Ms. Irene, continuing) Did you form an opinion in this case about the use or lack of use of an EKG?

MR. KNOTT: Form.

A No.

MS. IRENE: Okay. I can just take a break for a couple minutes again so I can go over my notes.

THE VIDEOGRAPHER: And we are going off the record at 12:48 p.m.

(Off the record)

THE VIDEOGRAPHER: We are back on the record for the deposition of Kim Pearson being conducted by videoconference. Today is February 26th, 2025, and it is 12:59 p.m. Central.

Q (By Ms. Irene, continuing) Ms. Pearson, I really do not have many more questions for you. We are nearing the end. Like I said, I can't speak for everyone else, but we are.

Did you form an opinion as to the adequacy of ACH's training materials?

A I reviewed some of the training materials. I did not -- I was not asked to review those from that perspective.

What I can say about what I looked at was that based on RN Fennigkoh's actions and treatment, that she clearly had been trained. So she was, again, performing and meeting the standard of care appropriately.

Q Okay. Is my understanding correct that independent of Amber Fennigkoh, you did not form an opinion -- you did not form an opinion on

ACH's training materials?

MR. KNOTT: Object to the form of the question.

A I'm sorry, go ahead.

MR. KNOTT: I objected to the form of the question, but I think you answered.

A Just as I said before, ACH in terms of -- reflected in the services reflected in Nurse Fennigkoh's actions and care and treatment, she -- the training was appropriate.

Q (By Ms. Irene, continuing) In your report you don't reference any specific ACH orientations or training policies or manuals and give a conclusion about their adequacy, do you?

A No, I don't believe so. Again, you know, I was asked to review this in terms of RN Fennigkoh and meeting the standard of care and if there was any evidence that she disregarded in any way Ms. Boyer, so.

Again, it all -- her actions and the way she conducted her nursing care is reflective of appropriate training.

Q Looking at page 15 of your report, you cite the National Commission on Correctional Health Care Standards for Health Services in Jails, and I'm

referring to where you cite section JA01, Access to Care.

A Yes.

Q And you state, Access to care means that -- I apologize. I withdraw the question.

And when you're citing that you wrote in your report, Access to care means that in a timely manner, a patient can be seen by a clinician, be given a professional clinical judgment, and receive care that is ordered.

Do I have that right?

A Yes, that's what I wrote.

Q Was Ms. Boyd ever seen in person by a nurse practitioner? Or I'm sorry, I apologize. Ms. Boyer.

MR. KNOTT: Form.

A I don't believe so, but that's not what the standard requires. It's -- actually, I believe the term is "qualified health professional" which includes a nurse, so she was seen by a nurse.

Q (By Ms. Irene, continuing) So to be clear, you're saying that on page 15, looking at the section where it says a patient can be seen by a clinician, you're saying that the term is actually qualified health professional?

A Well, I don't have quotes around this, so. I believe it does say "qualified health professional", which by definition is a nurse, a licensed mental health provider, a nurse practitioner. It's any number of qualified licensed providers.

Q Okay. One moment. And under this -- I apologize. I withdraw the question.

Looking again at the Standards for Health Services in Jail section JA01, is part of the standard of care that a face-to-face exam is given?

MR. KNOTT: Object to the form. It's vague.

A Well, no, and these standards are not standard of care. This is not standard of care. These are accreditation standards. But the answer is still no.

Q (By Ms. Irene, continuing) Okay. So when it says access to care means that in a timely manner a patient can be seen by a clinician or a qualified health professional, what does "seen by" mean?

A Well, I did not write the standard.

Q If you do not know, you are more than -- I don't want you to answer something that you don't know

the answer to. If you do not know, that is an acceptable answer.

A Right. I didn't -- I didn't write the standard. It's just access to care that a patient is seen by a qualified healthcare professional. So I don't know what they meant when they wrote that.

But regardless, she was seen by a qualified health professional.

Q Okay. I'm going to share my screen again.

Ms. Pearson, have you seen this document before?

A Perhaps. I would need to reread it.

Are you going to ask me -- should I read it? Are you going to ask me questions about it?

Q Yes. Please take a moment to reread it.

MR. KNOTT: Madison, when she's done, would you mind scrolling down for a Bates number? Wait until she says she's done.

MS. IRENE: Yes. Thank you.

A Okay.

Q (By Ms. Irene, continuing) Okay. And for the record, the document that Ms. Pearson was reviewing was Monroe County Bates No. 017959.

Is this an email sent to -- or sorry, sent from Amber Fennigkoh?

A Yes.
Q And in this email does Ms. Fennigkoh express concerns about sending -- about the frequency with which the jail is sending inmates to the emergency room?
MR. KNOTT: Vague. Foundation.
A I'm going to say no to that. This is -- this email is covering several different things. I -- my -- just reading it now, my take on this is that Nurse Fennigkoh is asking questions that I think she's just trying to be concerned about processes and what's, you know, the best way to handle various situations. And I just don't have any more context other than this email.
Q (By Ms. Irene, continuing) Ms. Pearson, to be clear, have you seen this email before?
A You know, I believe I did, but it really wasn't related to this, the care, what was going on in this particular case.
So I believe I saw it. I just didn't pick it apart because it really wasn't relevant to this case from my perspective of what I was asked to do.
Q Okay. One moment. Did you form an opinion on whether or not the -- I'm sorry. Hang on one

second.

Have you seen this email before?

MR. KNOTT: Bates number?

MS. IRENE: Yes, I apologize. Thank you.

Q (By Ms. Irene, continuing) Have you seen this email before? This is Bates No. Monroe County 018773.

A Again, yes. I believe I reviewed this. But again, I did not -- I didn't spend any time picking it apart again because it wasn't necessarily relevant to what I was asked to do in this particular case.

Q Have you seen -- sorry. I'm not sure if you heard my question or if I was on mute again.

Have you seen this email before?

A I believe so, yes.

MR. KNOTT: I think she just answered.

Q (By Ms. Irene, continuing) Okay. And did you consider it in forming your opinions in this case?

A No, in terms of this is a discussion about services in general and the best way to manage that, and it really wasn't applicable per se to

this case with Ms. Boyer.

Q Okay. And just to be clear in case I was on mute when I said this because I'm not sure when I went on, but this is Bates Monroe County 056584.

Ms. Pearson, do you believe that people in prison deserve the same access to healthcare as those who are not in prison?

MR. KNOTT: Object to the form.

A In jail and prison, yes. It's just access to care, as with any venue, looks different based on your resources.

So, for instance, if you're in the emergency room and you start to have a stroke there's a doctor right there, you're in the emergency room.

If you start to have a stroke at a jail, 911 is called and you're transported to the emergency room. So it's access to care. It's just accomplished in a different way based on the resources available.

But yes, as we call them patients, not inmates, the patients absolutely deserve access to care and their healthcare needs met. That's the purpose of correctional health care companies providing correctional health.

Q (By Ms. Irene, continuing) And do you believe

that patients who are incarcerated deserve the same standard of medical care as those who are not incarcerated?

MR. KNOTT: Object to the form of the question. Object to the extent it's vague as to "standard". If it's standard of care, it's a legal question. But go ahead.

A Could you repeat the question, please.

Q (By Ms. Irene, continuing) Do you believe that people who are incarcerated deserve the same standard of medical care as those who are not incarcerated?

A Well, again, standard of care is what would the same or similar person do in the same or similar situation. So again, I'm back to it depends on your resources and how you accomplish standard of care.

There are -- well, they deserve to have their healthcare needs met, it's just accomplished in different ways based on the venue. As my example before, if you're in the emergency room versus in a jail, you're having a stroke, that's handled two different ways. You're still getting access to care, it just has to be accomplished differently.

MS. IRENE: Okay. I have no further questions. Thank you very much for your time, Ms. Pearson.

MR. JONES: I do not have questions.

MR. HARDY: I have no questions.

MR. KNOTT: Ms. Pearson, I have just a couple of clarifications.

EXAMINATION

BY MR. KNOTT:

Q Just prior to the last break a question was asked about whether you had formed an opinion, and I don't remember exactly how it was phrased, whether you had formed an opinion with respect to an EKG, and I think your answer was no.

Did you form an opinion as to whether the standard of care required Amber Fennigkoh to send Ms. Boyer to a hospital to get an EKG at any time?

A Yes, I do have an opinion about that. And my opinion is that no, Nurse Fennigkoh was never in a position where the standard of care would require her to send Ms. Boyer to the hospital for an EKG. RN Fennigkoh was not even in the building at the time that Ms. Boyer experienced chest pain and she was --

Q Okay. And the last question, you were asked questions about NCCHC Standard JA01 Access to Care and how you quoted that, or you cited that on page 15 of your report.

A Yes.

Q Do you have that in front of you now?

A Yes.

Q And just with respect -- so the record is clear, with respect to the term "clinician", what is your opinion with respect to the use of the word "clinician" in JA01?

A A licensed healthcare staff member. NCCHC they do use the term "qualified healthcare professional."

In the back of the standards book they define what that is, and it is a licensed healthcare professional such as a nurse, a licensed mental health worker, a physician. It goes through the gamut of licensed healthcare workers who are able to provide -- who are able to see the patient.

Q And is it my understanding you substituted when you're writing your report "clinician" for qualified healthcare provider -- or "qualified healthcare professional"?

A Yes.
Q And in retrospect, is that a choice you would make again?
A In retrospect, I'm changing that when we're finished here today.
Q And that's it?
A To be clear, yes. Again, it's not in quotes. The standards, the National Commission standards book is many, many, many pages long and there's a lot of information. I mean, I can't, short of photocopying the book and attaching it, just was trying to offer the intent of the standards.

So clinician covers licensed healthcare workers, so. But I will change that to make that clearer in the future.

MR. KNOTT: Okay. That's all I have. Thank you.

THE VIDEOGRAPHER: Is there any follow-up based on that?

MS. IRENE: No. No further questions based on that.

THE VIDEOGRAPHER: All right. And just before I take us off the record I do have to get orders.

So Madison, would you like the

transcript or the video?

MS. IRENE: Not at this time. No, thank you.

THE VIDEOGRAPHER: All right. Douglas, transcript or the video?

MR. KNOTT: Not at this time. Thank you.

THE VIDEOGRAPHER: All right. Mark, transcript or the video?

MR. HARDY: No, thank you.

THE VIDEOGRAPHER: And Andrew, transcript or the video?

MR. JONES: Same answer. No.

THE VIDEOGRAPHER: All right. Then we are going off record. It is 1:20 p.m. Central.

(Off the video record)

MR. KNOTT: You know, I'm not sure who was asking the question there, but was that transcript? We need a transcript. We're not going to pay for the original, so. That's a thing we play with the Loevy firm, so.

I'm going to order a transcript of the deposition, but I'm not going to pay for the original. So if you're going to insist that

I pay for the original, then I'm not going to order the transcript.

MS. MAKAR: That's fine.

MR. KNOTT: So is Loevy going to order the transcript?

MS. MAKAR: Why don't you just tell Talia that you don't want a transcript unless the original is ordered, Doug.

MR. KNOTT: Yeah, that's what I'm saying.

MS. MAKAR: Okay.

THE VIDEOGRAPHER: Okay. Understood.

MR. KNOTT: Okay.

COURT REPORTER: So I just need to, for my mind, nobody is ordering a paper transcript/electronic transcript of Ms. Pearson; is that correct?

MS. MAKAR: Yes, not at this time.

COURT REPORTER: Mr. Knott; right?

MR. KNOTT: Yep. We'll be in touch.

(The videoconference deposition of Kimberly Pearson came to a close at approximately 1:20 p.m.)

* * *

STATE OF WISCONSIN)
COUNTY OF ST. CROIX)

Be it known that I took the videoconference deposition of Kimberly Pearson, on the 26th day of February, 2025, remotely via Zoom;

that I was then and there a Notary Public in and for the County of St. Croix, State of Wisconsin, and that by virtue thereof I was authorized to administer an oath;

that the witness, before testifying, was by me first duly sworn to testify to the whole truth and nothing but the truth relative to said cause;

that the testimony of said witness was recorded in stenotypy by myself and reduced to print by means of Computer-Assisted Transcription under my direction, and that the deposition is a true record of the testimony given by the witness to the best of my ability;

that I am not related to any of the parties hereto nor interested in the outcome of the action.

Dated this 24th day of March, 2025.

Terri Stacken, RPR
St. Croix County, Wisconsin
Commission Expires
10-29-2026

EXHIBITS